

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06224

FOR STATE
HEALTH DEPT.

(M)

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ma</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Berlin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Berlin</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs</u>		d. STREET ADDRESS <u>R2D 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>R</u> Middle <u>Baker</u> Last		4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>19 61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2-1923</u>
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Capt. Jug boat</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ida</u>	
11. BIRTHPLACE (State or foreign country) <u>Ma</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James L. Baker</u>		14. MOTHER'S MARDEN NAME <u>Lida Pointer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>129-10-2291</u>	
17. INFORMANT <u>Mrs. Margaret Hedson</u> Address <u>Bishop, Ma</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Neglected untreated chest cold</u> caused the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C</u> <u>alcoholism</u> <u>Arthritis</u> <u>Deformities</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>N.E. Sartorius Sr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius Sr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REBURY (a) <u>Burial</u>		22b. DATE THEREOF <u>5/12/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Church Yard</u>		22d. LOCATION (City, town, or county) (State) <u>Bishop, Ma.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley</u> ADDRESS <u>Sallyville, Md.</u>		24a. REC'D BY REGISTRAR <u>DAY 17 '61</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kump</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8933

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1933

<p>1. NAME OF DECEASED: <i>John Doe</i></p>		<p>2. SEX: <i>Male</i></p>	
<p>3. AGE: <i>45</i></p>		<p>4. DATE OF BIRTH: <i>Jan 15, 1888</i></p>	
<p>5. PLACE OF BIRTH: <i>Johns Hopkins</i></p>		<p>6. OCCUPATION: <i>Physician</i></p>	
<p>7. MARITAL STATUS: <i>Married</i></p>		<p>8. DATE OF MARRIAGE: <i>Jan 1, 1910</i></p>	
<p>9. PLACE OF DEATH: <i>Johns Hopkins</i></p>		<p>10. DATE OF DEATH: <i>Jan 1, 1933</i></p>	
<p>11. CAUSE OF DEATH: <i>Heart failure</i></p>		<p>12. MANNER OF DEATH: <i>Natural</i></p>	
<p>13. SIGNATURE OF EXAMINER: <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>15. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>16. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>17. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>18. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>19. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>20. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>21. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>22. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>23. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>24. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>25. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>26. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>27. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>28. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>29. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>30. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>31. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>32. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>33. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>34. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>35. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>36. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>37. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>38. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>39. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>40. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>41. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>42. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>43. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>44. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>45. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>46. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>47. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>48. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>49. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>50. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>51. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>52. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>53. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>54. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>55. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>56. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>57. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>58. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>59. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>60. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>61. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>62. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>63. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>64. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>65. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>66. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>67. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>68. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>69. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>70. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>71. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>72. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>73. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>74. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>75. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>76. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>77. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>78. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>79. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>80. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>81. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>82. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>83. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>84. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>85. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>86. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>87. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>88. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>89. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>90. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>91. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>92. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>93. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>94. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>95. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>96. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>97. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>98. SIGNATURE OF WITNESS: <i>John Doe</i></p>	
<p>99. SIGNATURE OF WITNESS: <i>John Doe</i></p>		<p>100. SIGNATURE OF WITNESS: <i>John Doe</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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6235

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06225

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>R.F.D.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>REBECCA BAKER DOWNS</u>				4. DATE OF DEATH Month Day Year <u>MAY 20 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 13, 1874</u>	
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LITTLETON B. SMALLWOOD</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANNE TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MRS. KATHENE WINKLER, PHILA. PA</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Attack (Dilated)</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1960</u> to <u>May 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 19, 1961</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Chas. R. Law</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 22 '61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas. R. Law</u>				22d. ADDRESS <u>Berlin Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/23/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>TAYLORVILLE</u>		23d. LOCATION (City, town, or county) (State) <u>BERLIN RFD MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>				ADDRESS <u>Berlin Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 24 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

(M)

0332

CERTIFICATE OF DEATH

0332

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *65*
4. Date of birth: *1945-10-15*
5. Date of death: *2010-11-20*
6. Place of death: *Home*
7. Cause of death: *Heart failure*
8. Signature of doctor: *[Signature]*
9. Signature of registrar: *[Signature]*
10. Date of registration: *2010-11-25*

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06226

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newark Rural</i>		c. LENGTH OF STAY IN 1b <i>2 mo</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Andrew Whaley Foreman</i>		4. DATE OF DEATH Month <i>5</i> Day <i>1</i> Year <i>1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 1 - 61</i>
9. AGE (In years last birthday) <i>2</i> yrs.		10. IF UNDER 1 YEAR Months <i>2</i> Days <i>2</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sleeping baby</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>1</i>	
11. BIRTHPLACE (State or foreign country) <i>Newark, Md</i>		12. CITIZEN OF WHAT COUNTRY <i>1</i>	
13. FATHER'S NAME <i>Andrew Whaley</i>		14. MOTHER'S MAIDEN NAME <i>Clara Mae Foreman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>0</i>	
17. INFORMANT <i>Clara Mae Foreman</i>		Address <i>Newark, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia (probably)</i> <i>493X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Chest Cold.</i> (c), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH <i>?</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>N.E. Sartorius Sr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>N.E. Sartorius</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 2/61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>William Kennedy</i>		22d. LOCATION (City, town, or county) (State) <i>Newark, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clay E. Dumas</i>		24a. REC'D BY REGISTRAR <i>DATE 4 '61</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Knecht</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

NOV 10 1934

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>Male</i>	RACE <i>White</i>
RESIDENCE <i>123 Main St. Baltimore, Md.</i>		OCCUPATION <i>Teacher</i>		
DATE OF DEATH <i>Nov 8, 1934</i>		PLACE OF DEATH <i>Home</i>		
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>		
DISEASE OR INJURY <i>Coronary Artery Disease</i>		OTHER CAUSE OF DEATH <i>None</i>		
SIGNATURE OF EXAMINER <i>Dr. J. H. Smith</i>		DATE <i>Nov 10, 1934</i>		
OFFICE OF THE MEDICAL EXAMINER <i>Baltimore, Md.</i>		STATE OF MARYLAND		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6241

06227

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
c. LENGTH OF STAY IN 1b 32 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 606 Market Street		d. STREET ADDRESS 606 Market Street	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First HOWARD Middle C. Last GIBSON		4. DATE OF DEATH Month May Day 25 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1879
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Store	11. BIRTHPLACE (State or foreign country) Maryland
		12. CITIZEN OF WHAT COUNTRY? USA	

13. FATHER'S NAME Clayton Gibson		14. MOTHER'S MAIDEN NAME Margaret Gibson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-32-0597	
		17. INFORMANT Mrs Lillian Gibson, 606 Market St. Pocomoke City, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Degenerative Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) a. Chronic Bronchitis b. Emphysema.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **Oct. 1950** to **May 25, 1961**, that (I) (we) last saw the deceased alive on **May 25, 1961**, and that death occurred at **9:45 A.M.** from the causes and on the date stated above.

22a. SIGNATURE Charles W. Trader	22b. DATE 5/26/61
22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.	22d. ADDRESS 302 Market St., Pocomoke City, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-28-61	23c. NAME OF CEMETERY First Baptist	23d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland
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24. FUNERAL DIRECTOR'S SIGNATURE Henry G. Watson	25a. REC'D BY REGISTRAR MAY 31 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Krasner
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF BIRTH

1927

(M)

Name of child		Sex		Date of birth	
William Franklin		Male		Nov. 22, 1927	
Place of birth		Race		Color	
Baltimore City, Maryland		White		White	
Address of parents		Occupation of father		Occupation of mother	
606 Market Street		General Store		Housewife	
Name of father		Name of mother		Name of informant	
William Gibson		Mary Gibson		Mary Gibson	
Signature of father		Signature of mother		Signature of informant	
[Signature]		[Signature]		[Signature]	
Date of registration		Place of registration		Name of registrar	
Nov. 22, 1927		Baltimore City, Md.		[Signature]	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
6242 06228											
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL-Berlin</u> c. LENGTH OF STAY IN 1b <u>2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R3 Berlin Germantown Rd</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Wor</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Berlin</u> d. STREET ADDRESS <u>R3 Berlin Germantown Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Claude Elwood Hall</u> First Middle Last					4. DATE OF DEATH <u>May 21 1961</u> Month Day Year						
5. SEX <u>M</u>		6. COLOR OR RACE <u>NEURO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4 1891 69</u> yrs. Months Days		9. AGE (In years last birthday) <u>69</u> Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ambulance Attendant</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Jefferson Hall</u>					14. MOTHER'S MAIDEN NAME <u>ANNA ?</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>055-091340</u>					17. INFORMANT <u>MRS Bertie Hall (wife)</u> address <u>R3 Berlin Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221</u> DUE TO <u>Pulmonary Edema, Acute</u> Conditions, if any, which gave rise to immediate cause (b) <u>A.S.C.U.D.</u> stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>Approx 4 hours</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Francis J. Townsend Jr</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>May 21, 61</u>	
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND JR</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address <u>Salisbury Md.</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>5-24-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Berlin, Md.</u>				
23. FUNERAL DIRECTOR <u>Thornton B. Jolley, Salisbury, Md.</u>					24a. REC'D BY REGISTRAR <u>MAY 29 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur P. Hines</u>				

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6243

06229

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) 903 Second Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MOLLIE Middle S. Last HITCHENS				4. DATE OF DEATH Month May Day 23 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1877	
9. AGE (In years last birthday) 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John D. Stevens		14. MOTHER'S MAIDEN NAME Amamda Brittingham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Miss Iris Hitchens, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis.							INTERVAL BETWEEN ONSET AND DEATH 30 Min. years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Feb. 15, 1961 to May 23, 1961 , that (I) (we) last saw the deceased alive on May 23, 1961 , and that death occurred at 5 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles W. Trader				22b. DATE SIGNED May 24, 1961		22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.	
22d. ADDRESS 302 Market St., Pocomoke City, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-25-61		23c. NAME OF CEMETERY Salem Methodist		23d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson				25a. REC'D BY REGISTRAR DATE MAY 29 '61		25b. REGISTRAR'S SIGNATURE William L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1922

Worcester

Worcester

Worcester

Goodman St.

Life

Goodman St.

203 Second Street

203 Second Street

May 22 1922

May 22 1922

May 22 1922

Worcester

Worcester

Worcester

Worcester

203 Second Street

Worcester, Massachusetts

Worcester, Massachusetts

May 22 1922

Worcester, May 22 1922

Worcester, May 22 1922

Worcester, May 22 1922

Worcester, May 22 1922

Worcester, May 22 1922

Worcester, May 22 1922

Worcester, May 22 1922

XXXXXX

Worcester, May 22 1922

Worcester, May 22 1922

Worcester, May 22 1922

Worcester, May 22 1922

Worcester, May 22 1922

Worcester, May 22 1922

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6244

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06230

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Greenbackville, Virginia				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Greenbackville, Virginia			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----				d. STREET ADDRESS -----			
3. NAME OF DECEASED (Type or print) First MARION Middle -- Last KRZYZEWSKI				4. DATE OF DEATH Month May Day 1 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-20-1909	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired ChBos.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Felix Krzyzewski				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes WW 2		16. SOCIAL SECURITY NO. 217-42-6157		17. INFORMANT Robert Seichter, 217th B. Orchard St. Wallingford, Conn.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Disease (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Very brief						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE N. E. Sartorius Sr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) N. E. SARTORIUS, SR.		DATE SIGNED 1/2/61					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY	22d. LOCATION (City, town, or county) (State)				
Burial	May 4, 1961	St. Stanislaus	Meriden, Connecticut				
23. FUNERAL DIRECTOR'S SIGNATURE Henry P. Watson		ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR MAY 4 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kneass		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

6245
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06231

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b 12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1002 Second Street				d. STREET ADDRESS 1002 Second Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JERMOND Middle LEE Last MARRINER				4. DATE OF DEATH Month May Day 7 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 8, 1912	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 49 Days 49 Hours 49 Min.		IF UNDER 24 HRS. Months 49 Days 49 Hours 49 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Reader		10b. KIND OF BUSINESS OR INDUSTRY Gas Company		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert H. Marriner				14. MOTHER'S MAIDEN NAME Lula E. Thornton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-01-2875		17. INFORMANT Address 1002 Second St. Mrs Mildred H. Marriner, Pocomoke, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 163X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombo-phlebitis, arms and legs.						INTERVAL BETWEEN ONSET AND DEATH 3 Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1, 1961 to May 7, 1961 , that (I) (we) last saw the deceased alive on May 7, 1961 , and that death occurred at 950 PM from the causes and on the date stated above.							
22a. SIGNATURE Charles W. Trader				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 8, 1961	
22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.				22d. ADDRESS 302 Market St., Pocomoke City, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 10, 1961		23c. NAME OF CEMETERY OR CREMATORIUM Wattsville Methodist		23d. LOCATION (City, town, or county) (State) Wattsville, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson				ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR DATE MAY 11 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Frawley			

2352

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6246

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ma</i> b. COUNTY <i>Worcester</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill - Rural</i>		c. LENGTH OF STAY IN <i>30 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill - Rural</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <i>15</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Avary</i> First <i>Thomas</i> Middle <i>Melton</i> Last				4. DATE OF DEATH Month <i>5</i> Day <i>19</i> Year <i>1961</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 9th 1900</i>		9. AGE (In years to birthday) <i>60</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter & Carpenter Tradesman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Snow Hill, Md.</i>		11. BIRTHPLACE (State or foreign country) <i>Ma</i>	
13. FATHER'S NAME <i>John Melton</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Hubbard</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>None</i>			
17. INFORMANT <i>Narcissus Melton - (wife)</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Distress</i> <i>527.2</i> DUE TO (b) <i>1. Pulmonary Edema</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Heavy Cigarette Smoker</i> INTERVAL BETWEEN ONSET AND DEATH <i>Several hours</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>N.E. Sartorius</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <i>N.E. Sartorius</i>				DATE SIGNED <i>5/19/61</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>May 21/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Catholic Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Snow Hill Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wayne Dumas</i>				ADDRESS <i>Snow Hill Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>	
24a. REC'D BY REGISTRAR DATE <i>MAY 23 '61</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely read in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
6247						06233					
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Worcester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville				d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) XXX						e. STREET ADDRESS 1					
3. NAME OF DECEASED (Type or print) GEORGE WILLIAM PHILLIPS						4. DATE OF DEATH Month May Day 2 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 5, 1896		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker				10b. KIND OF BUSINESS OR INDUSTRY Lumber Truck		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joshua Phillips						14. MOTHER'S MAIDEN NAME Alice Fleetwood					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 217-26-0356		17. INFORMANT Hazel Phillips		Address Whaleyville, Md.			
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Malnutrition Conditions, if any, which gave rise to immediate cause (b) Malnutrition (c) Malnutrition DUE TO Malnutrition cause last. (c) Malnutrition PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 163X											
INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. 19 p.m.		Month, Day, Year 15-28-61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8-1		20f. (City or town) 60-5-2-61		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 15-28-61 to 15-28-61 , that (I) (we) last saw the deceased alive on 15-28-61 , and that death occurred at 11:15P , from the causes and on the date stated above.											
22a. SIGNATURE Clifford E. Schott M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type or print) CLIFFORD E. SCHOTT MD						22d. ADDRESS BERLIN MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/5/61		23c. NAME OF CEMETERY OR CREMATORY Dale		23d. LOCATION (City, town or county) (State) Whaleyville, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Selbyville, Del.						25a. REC'D BY REGISTRAR DATE MAY 5 '61		25b. REGISTRAR'S SIGNATURE Clifford E. Schott			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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6248
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
06234

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b <u>40 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Commerce</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>JANE</u> Last <u>PHILLIPS</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 17, 1869</u>		9. AGE (In years last birthday) <u>92</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>GOSHEN OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN PRICE PORTER</u>				14. MOTHER'S MAIDEN NAME <u>JULIA HARRIST PETERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NO</u>		17. INFORMANT Address <u>MRS. HELEN TODD, BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> <u>422.1</u> DUE TO (b) <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 1961, to <u>May 19</u> 1961, that (I) (we) last saw the deceased alive on <u>May 18</u> 1961, and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Chas. R. Law</u>				22b. DATE SIGNED <u>5-20-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Berlin Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/21/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 23 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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6249
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
06235

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Stockton		c. LENGTH OF STAY IN 1b 32 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Stockton		d. STREET ADDRESS R.F.D. 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle FLORENCE Last PILCHARD		4. DATE OF DEATH Month May Day 16 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1896
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward S. Pettit		14. MOTHER'S MAIDEN NAME Sarah Wise Mills	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. None	
17. INFORMANT Owen P. Pilchard, Stockton, Maryland		Address R.F.D. 1	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia and Inanition 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Adenocarcinoma of rectum DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 month 2 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bowel obstruction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 1959 , to May 16 1961 , that (I) met last saw the deceased alive on May 15 1961 , and that death occurred at 1:45 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Robert C. LaMar M.D.		22b. DATE SIGNED May 17, 1961	
22c. PHYSICIAN'S NAME (Type) Robert C. LaMar, M. D.		22d. ADDRESS 104 Bay Street, Snow Hill, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-18-61	23c. NAME OF CEMETERY Pocomoke	23d. LOCATION (City, town, or county) (State) Worcester County, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR DATE MAY 19 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

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CERTIFICATE OF DEATH

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Barry - Elizabeth

32 years

Barry - Elizabeth

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R.N. 1

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Female White

Female White

Housewife

Housewife

Edward S. Barry

Edward S. Barry

None

None

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Barry - Elizabeth

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Worcester City, Mass.

Worcester City, Mass.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06236

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del</u> b. COUNTY <u>Worcester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ironshire</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Post Hospital</u>			d. STREET ADDRESS <u>46x-3</u>		
3. NAME OF DECEASED (Type or print) <u>George Powell Jr.</u>			4. DATE OF DEATH <u>May 21 1961</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5 - 1905</u>		9. AGE (In years last birthday) <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child at home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>George Powell</u>			14. MOTHER'S MAIDEN NAME <u>Mildred Lockwood</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>142-12-10000</u>		
17. INFORMANT <u>Hazel Lockwood - Ironshire Md</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conflagration</u> 906.0 DUE TO <u>Gasoline Explosion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Kerosene</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 small children in a room - adults off visiting</u>		
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY <u>5</u> Hour <u>a.m.</u> <u>5-21-1961</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	
20f. (City or town) <u>Worc.</u>		20g. (County) <u>Md.</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>N.E. Sartorius Sr.</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/23/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zoar Methodist Cem.</u>	
22d. LOCATION (City, town, or county) <u>Selbyville</u>		22e. (State) <u>DELA</u>		22f. (County) <u>Worc.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley, Salisbury, Md.</u>			24a. REC'D BY REGISTRAR <u>MAY 29 '61</u>		
			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 Bay Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MINNIE CATHERINE POWELL</u>				4. DATE OF DEATH <u>May 21 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 30, 1877</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD (RFD)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LUCIEN WOOTEN</u>				14. MOTHER'S MAIDEN NAME <u>EMMA PARSONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MR. FRANKLIN POWELL</u>		Address <u>WILMINGTON DEL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Hypertensive & Sclerotic Heart Disease</u> DUE TO (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> <u>1961</u> , to <u>May</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>May 21 1961</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>David Rafat</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/23/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT</u>				22d. ADDRESS <u>Snow Hill Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/23/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOWEN</u>		23d. LOCATION (City, town, or county) (State) <u>NEWARK MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u>				ADDRESS <u>Berlin Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 25 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

1883

CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Age: _____

3. Sex: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Signature of Physician: _____

8. Signature of Coroner: _____

9. Signature of Registrar: _____

10. Signature of Minister: _____

11. Signature of Undertaker: _____

12. Signature of Burial: _____

13. Signature of Interment: _____

14. Signature of Burial: _____

15. Signature of Interment: _____

16. Signature of Burial: _____

17. Signature of Interment: _____

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96. Signature of Burial: _____

97. Signature of Interment: _____

98. Signature of Burial: _____

99. Signature of Interment: _____

100. Signature of Burial: _____

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

6252
66238
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Mercer</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoddard</u> c. LENGTH OF STAY IN 1b <u>13 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Halland Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mercer</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoddard</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Annie Sue Pruitt</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 23-1880</u>		9. AGE (In years, last birthday) <u>80</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country) <u>Stoddard, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD</u>	
13. FATHER'S NAME <u>Robert Watson</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Powell</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. P. Kelly Berlin, MD</u> Address <u>Stoddard, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basilar Pneumonia, Terminal</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Breast with</u> DUE TO (c) <u>Brain metastases</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>342</u> <u>142</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> 19 to <u>May 1, 1961</u> that (I) (we) last saw the deceased alive on <u>May 1, 1961</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Paul Owen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>Snow Hill, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>May 3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Stoddard, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Dennis</u>				ADDRESS <u>Snow Hill, MD</u>		25a. REC'D BY REGISTRAR <u>May 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>	

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DEATH

OF

THE

STATE

OF

MASSACHUSETTS

1900

1901

1902

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WORCESTER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BISHOP c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Sister's home)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DELAWARE b. COUNTY SUSSEX c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SELBYVILLE d. STREET ADDRESS 46X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOWARD Middle DALE Last QUILLEN		4. DATE OF DEATH Month MAY Day 1 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 1, 1903
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11. BIRTHPLACE (State or foreign country) SHOWELL, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS QUILLEN		14. MOTHER'S MAIDEN NAME MARGARET TAYLOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 222-01-7763	
17. INFORMANT MR. WILBUR QUILLEN, BERLIN MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) (Cor myocardial rupture) DUE TO (c) Previous infarction about 1 1/2 yrs ago PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		INTERVAL BETWEEN ONSET AND DEATH instantly	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 1958 to present , that (I) (we) last saw the deceased alive on 18 Apr 1961 , and that death occurred at 6 PM , from the causes and on the date stated above.			
22a. SIGNATURE Earl B. McFadden		22b. DATE SIGNED 4 May '61	
22c. PHYSICIAN'S NAME (Type) Earl B. McFADDEN		22d. ADDRESS Selbyville, Del.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/5/61	23c. NAME OF CEMETERY OR CREMATORY EVERGREEN	23d. LOCATION (City, town, or county) (State) BERLIN MD
24. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burboze		25a. REC'D BY REGISTRAR Berlin Md	
25b. REGISTRAR'S SIGNATURE Charles S. Hines		DATE MAY 8 '61	

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Item 1d Film G286 5/12/61 ink

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[Faint, mostly illegible text, likely a birth or death record, with some handwritten entries.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6254

Reg. Dist. No. 16244

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> c. LENGTH OF STAY IN 1b <u>all his life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS _____				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>James</u> Middle <u>Rowley</u> Last				4. DATE OF DEATH <u>3</u> Month <u>31</u> Day <u>19</u> Year <u>61</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 22-1918</u>		9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labrador</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cannery</u>				11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Bettyman Rowley</u>				14. MOTHER'S MAIDEN NAME <u>Ola Maggie Gunn</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-05-3880</u>		17. INFORMANT <u>Harry F. Rowley</u> Address <u>Snow Hill</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> (b) <u>353.3</u> DUE TO <u>Epileptic attack (while in a pond)</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Deceased was an alcoholic</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Snow Hill</u>		20f. (City or town) (County) (State) <u>Worcester Md</u>				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>N.E. Sartorius, Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>5/2/61</u>			
EXAMINER'S NAME (Type) <u>N.E. Sartorius, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried May 4/61</u>			22b. DATE THEREOF <u>May 4/61</u>			22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>			22d. LOCATION (City, town or county) (State) <u>Snow Hill Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton D. Smith</u> Address <u>Snow Hill Md</u>						24a. REC'D BY REGISTRAR <u>Clayton D. Smith</u>		24b. REGISTRAR'S SIGNATURE <u>Clayton D. Smith</u>			
25. DATE OF DEATH <u>May 3/61</u>						26. DATE OF EXAMINATION <u>May 5 '61</u>		27. PLACE OF EXAMINATION <u>Snow Hill Md</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Deceased disappeared 3/30/61, found submerged 6 day 5/2/61 in shallow pond

WYOMING STATE DEPARTMENT OF HEALTH - BAYLOR 12 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. RACE [Faint text]</p>	
<p>5. DATE OF DEATH [Faint text]</p>		<p>6. TIME OF DEATH [Faint text]</p>	
<p>7. PLACE OF DEATH [Faint text]</p>		<p>8. OCCASION OF DEATH [Faint text]</p>	
<p>9. CAUSE OF DEATH [Faint text]</p>		<p>10. MANNER OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF MEDICAL EXAMINER [Faint text]</p>		<p>12. SIGNATURE OF WITNESS [Faint text]</p>	
<p>13. SIGNATURE OF DECEASED [Faint text]</p>		<p>14. SIGNATURE OF NEXT OF KIN [Faint text]</p>	
<p>15. SIGNATURE OF CLERK [Faint text]</p>		<p>16. SIGNATURE OF JURY [Faint text]</p>	
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<p>19. SIGNATURE OF JURY [Faint text]</p>		<p>20. SIGNATURE OF JURY [Faint text]</p>	
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<p>73. SIGNATURE OF JURY [Faint text]</p>		<p>74. SIGNATURE OF JURY [Faint text]</p>	
<p>75. SIGNATURE OF JURY [Faint text]</p>		<p>76. SIGNATURE OF JURY [Faint text]</p>	
<p>77. SIGNATURE OF JURY [Faint text]</p>		<p>78. SIGNATURE OF JURY [Faint text]</p>	
<p>79. SIGNATURE OF JURY [Faint text]</p>		<p>80. SIGNATURE OF JURY [Faint text]</p>	
<p>81. SIGNATURE OF JURY [Faint text]</p>		<p>82. SIGNATURE OF JURY [Faint text]</p>	
<p>83. SIGNATURE OF JURY [Faint text]</p>		<p>84. SIGNATURE OF JURY [Faint text]</p>	
<p>85. SIGNATURE OF JURY [Faint text]</p>		<p>86. SIGNATURE OF JURY [Faint text]</p>	
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<p>93. SIGNATURE OF JURY [Faint text]</p>		<p>94. SIGNATURE OF JURY [Faint text]</p>	
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<p>97. SIGNATURE OF JURY [Faint text]</p>		<p>98. SIGNATURE OF JURY [Faint text]</p>	
<p>99. SIGNATURE OF JURY [Faint text]</p>		<p>100. SIGNATURE OF JURY [Faint text]</p>	

(M)

(J)



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

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6255

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06241

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Worcester</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>			
c. LENGTH OF STAY IN 1b <i>14 yrs</i>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Unice M. Shackley</i>				4. DATE OF DEATH <i>May 7 1961</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 29 1888</i>	9. AGE (In years, if UNDER 1 YEAR, last birthday) <i>73-0-8</i>		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Washin, MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George W. Moore</i>				14. MOTHER'S MAIDEN NAME <i>Christiana Wainwright</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or date of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mr. Samuel E. Shackley, Snow Hill, MD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4200</i> DUE TO <i>Acute Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASHD</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Polyarthritis Nodosa</i>				INTERVAL BETWEEN ONSET AND DEATH <i>10 Min</i> <i>Years.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1961</i> to <i>May 7 1961</i> , that (I) (we) last saw the deceased alive on <i>May 7 1961</i> , and that death occurred at <i>8 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>David Rafat MD.</i>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>DAVID RAFAT</i>				22d. ADDRESS <i>Snow Hill</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>May 10/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph's Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Snow Hill MD</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wayne E. Dymus</i>				25a. REC'D BY REGISTRAR <i>May 9 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Hume</i>	

BP

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6256

Reg. Dist. No. 16242

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ironsburg</u>		c. LENGTH OF STAY IN 1b <u>all his life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Ironsburg</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Corlis</u> First <u>Dwight</u> Middle <u>Spence</u> Last		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 17-1960</u>
9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>01</u> Hours <u>01</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ironsburg Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Spence</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Budell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>17421 600000</u>	
17. INFORMANT <u>Bazel Lockwood</u> Address <u>Ironsburg Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conflagration</u> DUE TO <u>gasoline</u> Conditions, if any, which gave rise to immediate cause (b) <u>gasoline explosion</u> (c) <u>gasoline explosion</u> DUE TO <u>gasoline explosion</u> cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Young children left in a room adults visiting</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>while making a fire on gasoline</u>	
20c. TIME OF INJURY Month <u>5</u> Day <u>21</u> Year <u>1961</u> Hour <u>5</u> a. m. <u>21</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Ironsburg</u> (County) <u>Worcester</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N.E. Sartorius Sr</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-23-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN Cem</u>		22d. LOCATION (City, town, or county) <u>BERLIN, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley</u> ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 29 1961</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. F...</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Jan 15 1950</i>		6. TIME OF DEATH <i>10:00 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Myocardial Infarction</i>	
9. MANNER OF DEATH <i>Natural</i>		10. SIGNATURE OF EXAMINER <i>[Signature]</i>	
11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF CORONER <i>[Signature]</i>	
13. SIGNATURE OF MINISTER OF THE GOSPEL <i>[Signature]</i>		14. SIGNATURE OF CLERGYMAN <i>[Signature]</i>	
15. SIGNATURE OF CHURCH WARDEN <i>[Signature]</i>		16. SIGNATURE OF BURIAL SOCIETY <i>[Signature]</i>	
17. SIGNATURE OF FUNERAL HOME <i>[Signature]</i>		18. SIGNATURE OF CEMETERY <i>[Signature]</i>	
19. SIGNATURE OF HEALTH DEPARTMENT <i>[Signature]</i>		20. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>	
21. SIGNATURE OF CITY CLERK <i>[Signature]</i>		22. SIGNATURE OF STATE CLERK <i>[Signature]</i>	
23. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>		24. SIGNATURE OF CITY CLERK <i>[Signature]</i>	
25. SIGNATURE OF STATE CLERK <i>[Signature]</i>		26. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>	
27. SIGNATURE OF CITY CLERK <i>[Signature]</i>		28. SIGNATURE OF STATE CLERK <i>[Signature]</i>	
29. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>		30. SIGNATURE OF CITY CLERK <i>[Signature]</i>	
31. SIGNATURE OF STATE CLERK <i>[Signature]</i>		32. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>	
33. SIGNATURE OF CITY CLERK <i>[Signature]</i>		34. SIGNATURE OF STATE CLERK <i>[Signature]</i>	
35. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>		36. SIGNATURE OF CITY CLERK <i>[Signature]</i>	
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41. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>		42. SIGNATURE OF CITY CLERK <i>[Signature]</i>	
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45. SIGNATURE OF CITY CLERK <i>[Signature]</i>		46. SIGNATURE OF STATE CLERK <i>[Signature]</i>	
47. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>		48. SIGNATURE OF CITY CLERK <i>[Signature]</i>	
49. SIGNATURE OF STATE CLERK <i>[Signature]</i>		50. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>	
51. SIGNATURE OF CITY CLERK <i>[Signature]</i>		52. SIGNATURE OF STATE CLERK <i>[Signature]</i>	
53. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>		54. SIGNATURE OF CITY CLERK <i>[Signature]</i>	
55. SIGNATURE OF STATE CLERK <i>[Signature]</i>		56. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>	
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59. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>		60. SIGNATURE OF CITY CLERK <i>[Signature]</i>	
61. SIGNATURE OF STATE CLERK <i>[Signature]</i>		62. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>	
63. SIGNATURE OF CITY CLERK <i>[Signature]</i>		64. SIGNATURE OF STATE CLERK <i>[Signature]</i>	
65. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>		66. SIGNATURE OF CITY CLERK <i>[Signature]</i>	
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71. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>		72. SIGNATURE OF CITY CLERK <i>[Signature]</i>	
73. SIGNATURE OF STATE CLERK <i>[Signature]</i>		74. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>	
75. SIGNATURE OF CITY CLERK <i>[Signature]</i>		76. SIGNATURE OF STATE CLERK <i>[Signature]</i>	
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87. SIGNATURE OF CITY CLERK <i>[Signature]</i>		88. SIGNATURE OF STATE CLERK <i>[Signature]</i>	
89. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>		90. SIGNATURE OF CITY CLERK <i>[Signature]</i>	
91. SIGNATURE OF STATE CLERK <i>[Signature]</i>		92. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>	
93. SIGNATURE OF CITY CLERK <i>[Signature]</i>		94. SIGNATURE OF STATE CLERK <i>[Signature]</i>	
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97. SIGNATURE OF STATE CLERK <i>[Signature]</i>		98. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>	
99. SIGNATURE OF CITY CLERK <i>[Signature]</i>		100. SIGNATURE OF STATE CLERK <i>[Signature]</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06243

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Girl Townsend		4. DATE OF DEATH May 24 1961	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1961
9. AGE (In years last birthday) 12		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lee Townsend		14. MOTHER'S MAIDEN NAME Hazel Mason	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. John L. Townsend	
17. INFORMANT John L. Townsend		Address Stockton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURE BIRTH 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 24 May 1961 to 24 May 1961 , that (I) (we) last saw the deceased alive on 24 May 1961 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE H. Shelley MD.		22b. DATE SIGNED 24 May 61	
22c. PHYSICIAN'S NAME (Type) Henrik K Shelley		22d. ADDRESS Phincote Ave VA.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-27-61	
23c. NAME OF CEMETERY OR CREMATORY Tabernacle Cem.		23d. LOCATION (City, town, or county) (State) Hornstown Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, Va.		25a. REC'D BY REGISTRAR DATE JUN 5 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Worcester
Station

Worcester
Station

Baby Girl

Townsend

May 24 1883

Female Negro

John Lee Townsend
Harriet Mason

Child born

May 24 1883

Worcester

Worcester

Buried at 2:15 P.M. in the
Worcester